

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be reimbursement of \$48.00 for date of service 10/24/01.
- b. The request was received on 05/28/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. HCFA
  - c. TWCC 62 form
  - d. Letter dated 04/02/02 from the Carrier explaining reimbursement denial.
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file. There is no Carrier sign sheet in the dispute packet.

### **III. PARTIES' POSITIONS**

1. Requestor: The Requestor did not submit a position statement.

### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/24/01.
2. The denial codes listed on the EOB are "O- THE CARRIER PREVIOUSLY PROCESSED THIS BILL. BASED ON THE INFORMATION AVAILABLE, THE ORIGINAL AUDIT DECISION REMAINS THE SAME. IF YOU WISH FOR THE CARRIER TO RECONSIDER THIS BILL, PLEASE SUBMIT AS AN APPEAL." Letter dated 04/02/02 states: "Reimbursement is denied for the service billed as the documentation submitted does not support the specific level of service billed as it is defined in the 1998 TWCC Medical Fee Guideline. Rule 133.301 prohibits carriers from reimbursing a service at another billing code's value therefore no reimbursement can be recommended for the service billed in comparison with the documentation. Please submit a revised CPT code which may support the service billed."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
10/24/01	99214	\$125.00	\$0.00	T-F-N	\$71.00	MFG E/M (IV)(C)(2); CPT descriptor	“Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity.” The provider did not submit any medical documentation to support the CPT code billed. Therefore, reimbursement <b>is not</b> recommended.
<b>Totals</b>		\$125.00	\$0.00				The Requestor <b>is not</b> entitled to reimbursement.

The Above Findings and Decision is hereby issued this 1<sup>st</sup> day of November 2002.

Michael Bucklin  
Medical Dispute Resolution Officer  
Medical Review Division

MB/mb